U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 30 June 2005

In the Matter of:
INIS BELCHER (widow of
ELMER BELCHER, deceased)
Claimant

v.

Case Nos. 2003 - BLA- 00278
and 2003 - BLA- 00279

CHISHOLM MINE
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-In-Interest

Before: Daniel F. Solomon
Administrative Law Judge

DECISION AND ORDER - DENYING CLAIM[1]

JURISDICTION AND CLAIM HISTORY

This case comes on a request for a hearing pursuant to the provisions of Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. §§ 901 *et seq*. (the Act) dated June 4, 2003.[2] DX 129.[3]

A hearing was held on July 20, 2004, in Pikeville, Kentucky. The Claimant is represented by Susie Davis, Pikeville, Kentucky. Chisholm Mine (hereinafter "Employer") is represented by John Baird, Esq., and Lois A. Kitts, Esq., Baird & Baird, P.S.C., Pikeville, Kentucky. An appearance was entered for the Director, OWCP, who was not represented at the hearing. The Claimant appeared at the hearing and testified. One Hundred Thirty Eight (138) Director's exhibits, DX 1 through DX 138,[4] one (1) Claimant's exhibit, CX 1,[5] and seventeen

---

[1] 20 C.F.R. § 725.477, 5 C.F.R. § 554-7 (Administrative Procedure Act), and also 20 C.F.R. § 725.479 Finality of decisions and orders.

[2] And the regulations at 20 C.F.R. Ch. VI, Subchap. B (the Regulations).

[3] References to "ALJX", "CX", "DX" and "EX" refer to the exhibits of the Administrative Law Judge, Claimant, Director and the employer, respectively. The transcript of the hearing is cited as "Tr." and by page number.

[4] At Tr. 8, 10. The Claimant was afforded the opportunity to clarify the date on which the chest x-ray reread by Dr.

(17) Employer's exhibits, EX 1 through EX 17,[6] were admitted into evidence.

Before the undersigned are two consolidated claims. The Claimant is prosecuting the Living Miner's claim on behalf of her late husband, Elmer Belcher (the "Miner"). Mrs. Belcher is also seeking survivor's benefits. This decision relates to the modification of a duplicate miner's claim filed on August 8, 1996, DX 1, and the survivor's claim filed on December 23, 2000. DX 93. Because the claims at issue were filed after March 31, 1980, the regulations at 20 CFR Part 718 apply.[7] 20 CFR § 718.2. In reaching my decision, I have reviewed and considered the entire record, including all exhibits, the testimony at hearing and the arguments of the parties.

The Miner filed his initial claim for benefits under the Act on January 9, 1979. DX 48-174. He also submitted an interim filing on February 5, 1981. DX 48-167. This claim was finally denied on June 6, 1984 after a formal hearing by Administrative Law Judge George Morin. DX 48-1.

Mr. Belcher filed the instant duplicate claim on August 8, 1996. DX 1. This claim was administratively denied on December 9, 1996, DX 19, and again on January 27, 1997. DX 20. The denial was upheld by the District Director on August 7, 1997, after an informal conference, and on January 27, 1998 after the Miner requested modification. DX 45. The claim was referred to the Office of Administrative Law Judges at the Miner's request on May 4, 1998. DX 49. A formal hearing was conducted by Administrative Law Judge Daniel J. Roketenetz, and on August 31, 1999, Judge Roketenetz issued a Decision and Order Denying Benefits. DX 68. Following additional correspondence from the Miner, which was treated by the District Director as requests for modification, the claim was again referred on October 30, 2000 to this Office for a formal hearing. DX 84.

Mr. Belcher died on December 1, 2000. DX 87, DX 101. As noted above, Mrs. Belcher, the Claimant, filed for survivor's benefits on December 23, 2000. DX 93, DX 94. In view of this, the Miner's claim was remanded on January 13, 2001 to the OWCP for consolidation with the survivor's filing. DX 92. On April 11, 2001, both claims were administratively denied. DXs 113, 114. After the Claimant requested modification, the District Director issued two proposed Decisions and Orders denying the request for modification on September 5, 2002, DX 122, and on May 28, 2003 after the submission of additional evidence. DX 127. The Claimant requested a hearing, and that proceeding was conducted on July 20, 2004.

Patel was taken. DX 125. Tr. 31.

[5] At Tr. 11-12.

[6] At Tr. 25-26.

[7] The Department of Labor has amended the regulations that implement the Act. *See* 65 Fed. Reg. 80,045-80,107 (2000). The adjudication of these claims are subject to regulations as amended effective January 19, 2001 that relate to the standards of entitlement. 20 C.F.R. § 718.2 (2001). Unless otherwise indicated, citations are to the regulations as amended. Because both claims were "pending" on January 19, 2001, however, the provisions of the amended regulations that govern "subsequent claims," modification and that limit the development of medical evidence do not apply to the consideration of these claims. 20 C.F.R. § 725.2(c). *See* 68 Fed. Reg. 69935 (Dec. 15, 2003). A claim shall be considered "pending" if it was not finally denied more than one year prior to January 19, 2001, the effective date of the amended regulations. 20 CFR § 725.2(c). It should be noted that while Mrs. Belcher filed a supplemental claim form on January 26, 2001, DX 94, her earlier filing of a Survivor's Form has been treated as the filing of a survivor's claim.

Because Mr. Belcher's most recent coal mine employment occurred at a mine located in the Commonwealth of Kentucky, the rulings of the United States Court of Appeals for the Sixth Circuit govern the adjudication of this case. ***Danko v. Director, OWCP***, 846 F.2d 366, 368, 11 B.L.R. 2-157 (6th Cir. 1988). See ***Broyles v. Director, OWCP***, 143 F.3d 1348, 1349, 21 B.L.R. 2-369 (10th Cir. 1998); ***Kopp v. Director, OWCP***, 877 F.2d 307, 12 B.L.R. 2-299 (4th Cir. 1989); ***Shupe v. Director, OWCP***, 12 B.L.R. 1-200 (1989) (en banc).

Inis Belcher, the Claimant, testified at the hearing. She married Mr. Belcher on August 23, 1950. Tr. 14. Mrs. Belcher estimated that her husband worked in the mines for a total of 44 years. Id. She recalled that her husband had great difficulty in breathing, and was compelled to use oxygen until the day he died. Tr. 15. She had to help him through everyday activities. Tr. 16. Mrs. Belcher testified further that a doctor, most likely Dr. Sundaram although she could not recall exactly, told them that Mr. Belcher had black lung. Tr. 17-18, 20. She recalled that the Miner filed for benefits under the Act in 1979, but did not pursue the claim after it was denied. He filed again after his health worsened in 1996. Tr. 18. The Claimant did not say how many years Mr. Belcher smoked cigarettes.

Issues

These consolidated claims require the adjudication of a living miner's claim pursued on behalf of Mr. Belcher by his widow, Mrs. Belcher, and a survivor's claim. In a living miner's claim, it must be proven that: (1) the miner suffers from pneumoconiosis, (2) the pneumoconiosis arose out of coal mine employment, (3) the miner is totally disabled, and (4) the miner's total disability is caused by pneumoconiosis. ***Gee v. W. G. Moore and Sons***, 9 B.L.R. 1-4 (1986) (en banc); ***Baumgartner v. Director, OWCP***, 9 B.L.R. 1-65 (1986) (en banc). See ***Mullins Coal Co., Inc. of Virginia v. Director, OWCP***, 484 U.S. 135, 141, 11 B.L.R. 2-1 (1987). In order to establish entitlement to survivor's benefits under Part 718, the Claimant must establish that the miner suffered from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his death was due to pneumoconiosis. 20 C.F.R. §§ 718.1, 718.202, 718.203 and 718.205 (2002). With respect to the third element, the Claimant must submit competent medical evidence, which (1) establishes that the miner died due to pneumoconiosis; or (2) that pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or the death was caused by complications of pneumoconiosis; or (3) that the presumption of 20 C.F.R. § 718.304 (2001) is applicable.8 Pneumoconiosis constitutes a "substantially contributing cause" if it serves to hasten death in any way. 20 C.F.R. § 718.205(c)(5). ***Eastover Mining Co. Williams***, 338 F.3d 501, 508-09, 22 B.L.R. 2-625 (6th Cir. 2003); ***Brown v. Rock Creek Mining, Inc.***, 996 F.2d 812, 816, 17 B.L.R. 2-135 (6th Cir. 1993).

The failure to prove any requisite element precludes a finding of entitlement. ***Anderson v. Valley Camp of Utah, Inc***., 12 B.L.R. 1-111 (1989); ***Perry v. Director, OWCP***, 9 B.L.R. 1-1 (1986) (en banc).

The specific issues for adjudication in this case are:

1. Whether the Miner's claim is timely.

[8] Because there is no evidence of complicated pneumoconiosis in this record, the presumption at § 718.304 is inapplicable and will not be discussed further. I have also carefully considered Claimant's testimony, especially her recollection that the miner suffered from shortness of breath for some time prior to his death.

2. Whether the evidence establishes a material change in conditions since the final denial of the Miner's claim;
3. Whether the medical evidence establishes that the Miner suffered from pneumoconiosis;
4. If so, whether the Miner's pneumoconiosis arose at least in part out of his coal mine employment;
5. Whether the Miner suffered from a totally disabling pulmonary or respiratory impairment;
6. Whether any total respiratory disability was caused by pneumoconiosis. 20 C.F.R. § 718.204(c);
7. Whether the Miner's death was due to pneumoconiosis.

Stipulation and Withdrawal of Issues and Evidentiary Issues

At the hearing, the Employer withdrew as issues the Claimant's status as a dependent and qualified survivor and its status as responsible operator. The Employer also voiced no objection to the District Director's finding of twelve years of coal mine employment.

The Employer has challenged the admission of the x-ray reading by Dr. Patel. DX 125. This film was originally undated, and then a date from 2003 has been affixed to the x-ray report. I deny the Employer's motion to exclude this evidence, yet shall accord it diminished weight because of the failure accurately to establish the date on which the x-ray was taken.

Burden of Proof

"Burden of proof," as used in this setting and under the Administrative Procedure Act[9] is that "[e]xcept as otherwise provided by statute, the proponent of a rule or order has the burden of proof." "Burden of proof" means burden of persuasion, not merely burden of production. 5 U.S.C. § 556(d).[10] The drafters of the APA used the term "burden of proof" to mean the burden of persuasion. ***Director, OWCP, Department of Labor v. Greenwich Collieries [Ondecko],*** 512 U.S. 267, 18 B.L.R. 2A-1 (1994).[11] See ***Eastover Mining Co. Williams***, 338 F.3d at 508.

A Claimant has the general burden of establishing entitlement and the initial burden of going forward with the evidence. The obligation is to persuade the trier of fact of the truth of a proposition, not simply the burden of production, the obligation to come forward with evidence to support a claim. Therefore, the Claimant cannot rely on the Director to gather evidence. The Claimant bears the risk of non-persuasion if the evidence is found insufficient to establish a crucial element. ***Oggero v. Director, OWCP***, 7 B.L.R. 1-860 (1985).

---

[9] 33 U.S.C. § 919(d) ("[N]otwithstanding any other provisions of this chapter, any hearing held under this chapter shall be conducted in accordance with [the APA]"); 5 U.S.C. § 554(c)(2). Longshore and Harbor Workers' Compensation Act ("LHWCA"), 33 U.S.C. § 901-950, is incorporated by reference into Part C of the Black Lung Act pursuant to 30 U.S.C. § 932(a).

[10] The Tenth and Eleventh Circuits held that the burden of persuasion is greater than the burden of production, ***Alabama By-Products Corp. v. Killingsworth***, 733 F.2d 1511, 6 B.L.R. 2-59 (11th Cir. 1984); ***Kaiser Steel Corp. v. Director, OWCP*** [***Sainz***], 748 F.2d 1426, 7 B.L.R. 2-84 (10th Cir. 1984). These cases arose in the context where an interim presumption is triggered, and the burden of proof shifted from a Claimant to an employer/carrier.

[11] Also known as the risk of nonpersuasion, *see* 9 J. Wigmore, **Evidence** § 2486 (J. Chadbourn rev. 1981).

Length of Coal Mine Employment

The parties have not contested the length of Mr. Belcher's coal mine employment. The Claimant testified that he worked for 44 years in the mines. Previous administrative law judges have credited Mr. Belcher with 16 years. DX 48-1 and DX 68. I credit the Miner with 16 years of qualifying coal mine employment, which is consistent with his testimony in the first hearing. DX 48-26.[12]

Medical Evidence

As will be discussed below, the entire record shall be reviewed to determine in the survivor's claim whether the Miner suffered from pneumoconiosis. Although all relevant medical evidence is to be evaluated, and the exhibits submitted for the Miner's claim have been reviewed in their entirety, they will not be separately listed herein except as warranted by the discussion of issues for this survivor's claim. See ***Wheeler v. Apfel***, 224 F.3d 891, 895 n. 3 (8th Cir. 2000); ***Walker v. Bowen***, 834 F.2d 635, 643 (7th Cir. 1987), *overruled on other grounds*, ***Pope v. Shalala***, 998 F.2d 473 (7th Cir. 1993).

The record includes following medical evidence that has been submitted following the denial of benefits by Administrative Law Judge Roketenetz.

Death Certificate

The death certificate was filed on December 14, 2000. It had been certified on December 5, 2000 by Dr. Kathryn B. Jones, who concluded that the immediate cause of death was "acute myocardial infarction." CX 2.

Autopsy & Biopsy Report and Medical Opinions

Autopsy Report. DX 121.

An autopsy was conducted on December 2, 2000 at the Veterans Medical Center in Lexington by Dr. Yolanda M. Musgrave. Dr. Musgrave concluded that the cause of death was an "acute anteroseptal infarction." The anatomic diagnoses with respect to the lungs were "fibrosing alveolitis," "centrilobular emphysema," "lipomatous harmatoma, 1.5 cm, left upper lobe," and "marked congestion."

Dr. Musgrave commented as follows on the lung sections:

> The lung sections demonstrated pigment-laden macrophages interstitially, adjacent to bronchioles, in the subpleural parenchyma, and within peribronchial lymph nodes. This is a pattern commonly seen in urban dwellers and tobacco smokers. Changes consistent with fibrosing alveolitis or usual interstitial pneumonitis were seen. Alternating areas of normal lung, interstitial inflammation and fibrosis were present, with accentuation of the inflammation and fibrosis within the subpleural parenchyma. Coal nodules and large areas of fibrosis, characteristic of coal workers pneumoconiosis were not present. An incidental finding in the left upper lobe of lung was a lipomatous harmatoma. Focal intraparenchymal hemorrhage of the lung was in all likelihood a consequence of resuscitative efforts during the final code.

12 Mrs. Belcher did not testify as to the years of Mr. Belcher's cigarette smoking, although she iterated that in later years his representations to physicians about this habit were not accurate. He told Dr. Broudy in 1981 that he smoked one-half pack per day for 20 years. Dr. Broudy later recorded a smoking history of 30-40 pack/years. Dr. Westerfield recorded a more extensive smoking history of 46 pack/years. DX 9. Clinic notes have Mr. Belcher smoking for 30 years, and quitting 30 years before. DX 103. I find that Mr. Belcher smoked for 35 years at the rate of one pack per day.

> To summarize, the decedent had a known history of cardiovascular problems, which also included a history of abdominal aortic aneurysm repair and of a cerebral vascular accident. Furthermore he had suffered a previous myocardial infarction in 1989. Fibrosing alveolitis and chronic obstructive pulmonary disease complicated his cardiovascular status.

DX 121. The gross description of the lungs showed that they were "fibrous on the pleural surface." "Marked centrilobular emphysema" was present, "most apparent in the apices of both lungs." The microscopic examination showed a "confluent of alveolar spaces consistent with emphysema." Dr. Musgrave also detected "[p]igment-laden microphages" in the "interstitium near bronchioles" and also in the "subpleural parenchyma and in peribronchial lymph nodes." The slides also revealed that "[a]lveolar septa [were] widened by fibrosis in a patchy distribution with alternating areas of lung tissue, interstitial fibrosis and interstitial inflammation, predominately lymphocytic." A provisional anatomic diagnosis included "emphysema with apical bullae." DX 121.

Autopsy Consultation Report: Dr. Alex Racadag.

Dr. Racadag was presented with slides from the autopsy and also reviewed the autopsy report. He submitted his report on April 12, 2002. He diagnosed:

I. Centriacinar Emphysema.
II. Focal Pulmonary Anthracosis.
III. Focal Interstitial Fibrosis.
IV. Focal Congestion and Edema.
V. Lipomatous Harmatoma.

The doctor also opined that the diagnosed conditions contributed to the Miner's death. In describing the slides, the doctor concluded:

> Sections from both lungs show similar changes except for the lipomatous harmatoma. All slides show emphysematous changes represented by confluent enlargement of the airspaces accompanied by destruction of their walls with minimal fibrosis. Foci of interstitial thickening with collagen fibers and lymphocytes are noted. Focal subpleural, peribronchiolar and perivascular deposits of few black pigmented microphages without fibrosis also noted. Scattered similar anthracotic areas also noted randomly. Mucus-plugged bronchioles are present. The lipomatous harmatoma consist of mature fibroadipose tissue. All the slides show vascular congestion but only some slides show intra-alveolar red blood cells as well as eosinophilic material consistent with edema fluid.

CX 1.

Dr. John G. Boswell.

A surgical pathology report was submitted on October 7, 1998. DX 57. Dr. Boswell detected, based on slides prepared after a left lower lobe biopsy, "granulomatous inflammation. Increased anthracotic pigment." DX 57.

Dr. Gregory J. Fino. EX 1.

On June 15, 2004, Dr. Fino reported on his latest evaluation of the Miner's medical records. EX 1. He reiterated his opinion that the Miner was not afflicted with coal workers' pneumoconiosis, and opined that any respiratory disability suffered by Mr. Belcher was due to pleural effusions unrelated to coal mine dust inhalation. Dr. Fino continued:

> I think the additional medical information is helpful in showing that, indeed, he did have a chronic pulmonary condition that was diagnosed subsequent to my evaluation

in 1998. He had interstitial lung disease which was described as fibrosing alveolitis, or usual interstitial pneumonia, that was proven by autopsy and suspected by physicians. These are terms used to describe irregular interstitial fibrosis or what is now frequently ... called idiopathic pulmonary fibrosis. This is a disease of the general medical population and it is unrelated to the inhalation of coal mine dust.

There was no coal mine dust-related lung disease described by the prosector. I would note that anthracosis was described by Dr. Racadag. His exact terminology was "focal pulmonary anthracosis." His microscopic description was "focal sub-pleural, peribronchiolar and perivascular deposits of few black pigmented macrophages without fibrosis." Interestingly enough, this is not consistent with coal workers' pneumoconiosis based on my knowledge of coal workers' pneumoconiosis. Coal workers' pneumoconiosis is defined medically and pathologically as coal dust macules surrounded by interstitial fibrosis and focal emphysema. ...

As a pulmonary physician, this man did not have simple coal workers' pneumoconiosis and the "anthracosis" described by one pathologist is not, in my opinion, consistent with coal workers' pneumoconiosis.

I believe that this man had an interstitial pulmonary condition not related to the inhalation of coal mine dust. I believe that he was disabled from a pulmonary standpoint but that it was not contributed to or caused by the inhalation of coal mine dust. I do not believe that lung disease, regardless of cause, played any role in this man's death.

* * *

In conclusion, it is my opinion with a reasonable degree of medical certainty that this man did not have a coal mine dust-related lung condition. Also, it is my opinion that this man was not disabled in whole or in part by coal mine dust inhalation. I believe that he would have been disabled as I described above had he never stepped foot in the mines. His disability was due to interstitial lung disease or idiopathic pulmonary fibrosis. There is no causal connection between that condition and coal mine dust inhalation.

* * *

... He would have died as and when he did had he never stepped foot in the coal mines.

EX 1. Dr. Fino is board certified in internal medicine, with a subspecialty in pulmonary disease, and is a B-reader. He has been an Assistant Clinical Professor of Medicine at the University of Pittsburgh. EX 2.

Dr. P. Raphael Caffrey.

Dr. Caffrey conducted a review of the Miner's records at the request of the Employer and submitted his report on May 28, 2004. EX 3. Included in his review is a discussion of 32 slides that were submitted for evaluation. He observed that the lung slides revealed "fragments of lymph node material with a very mild amount of anthracotic pigment present." Dr. Caffrey added that

Overall these slides show a moderate degree of centrilobular emphysema. ... There is only a very mild amount of anthracotic pigment noted in a few areas, in fact most of the slides do not show anthracotic pigment. ... In some of the areas where the centrilobular emphysema is most prominent there is a mild degree of interstitial fibrosis with a scattering of mononuclear cells. ... There are no lesions of coal workers' pneumoconiosis (CWP), either simple or complicated on these ten slides. Under polarized light I did not identify any birefringent particles consistent with silica.

Dr. Caffrey did find indications of a "severe degree of atherosclerosis with 90-95% narrowing of the lumens with calcification" after reviewing the coronary artery slides.

He concluded:

> It is my opinion from a review of these multiple documents, the autopsy report and the autopsy slides that I am unable to make a diagnosis if CWP, either simple or complicated. The sections of lung tissue show only a very mild amount of anthracotic pigment in a few of the sections. The autopsy pathologist from the VA Hospital did not diagnose CWP grossly, microscopically, or on the final anatomic diagnosis sheet. Mr. Belcher had chronic bronchitis which I believe was mild, and a moderate degree of centrilobular emphysema but these were due to the patient's 45 year history of smoking cigarettes. ... It is important to note that in Dr. Broudy's report of July 28, 1997 he said that Mr. Belcher was seen at the pulmonary clinic on May 1, 1997 by Dr. Burki who said there was no evidence of CWP on chest x-ray but that he had "dirty lungs." According to that report of Dr. Broudy, Dr. Burki's note said Mr. Belcher was still smoking in July 1997 and the Doctor recommended the patient stop smoking.
>
> Mr. Belcher's medical problems were due to severe atherosclerosis and in my opinion the atherosclerosis was accelerated by his years of smoking cigarettes. The medical diseases the patient suffered from due to his severe atherosclerosis ... were in no way caused by or related to his employment in the coal mining industry. It should be pointed out that most all of the chest x-rays were interpreted as showing no evidence of CWP which certainly in this case correlates with what I see on the autopsy slides and correlates with what the autopsy pathologist found. Mr. Belcher at the time of death had a heart that weighed 580 grams which is almost twice normal, had severe coronary artery stenosis, and what I believe are acute ischemic changes[.] ... There is no clinical history on the autopsy report and I do not have a medical history regarding the last days or weeks of the patient's life.
>
> In summary, the fact that Mr. Belcher worked in the coal mines did not cause his pulmonary disability, and did not cause, contribute to or hasten his death. Mr. Belcher in my opinion would have died at the same time because of the severe degree of atherosclerosis that afflicted most of his arteries, whether or not he ever worked in the coal mines.

EX 3.

Dr. Caffrey's opinions were also presented in deposition testimony, and he explained that a survey of medical records would be an important supplement to a review of slides. EX 10 at 7, 10. He emphasized that the "gold standard to diagnose coal workers' pneumoconiosis are slides, particularly autopsy slides." EX 10 at 12.

He testified that the Miner had "some pulmonary impairment but it was not related to his employment in the coal industry." EX 10 at 12-13. He attributed this to both smoking and "secondary pulmonary problems" due to Mr. Belcher's cardiac condition. Id. Dr. Caffrey distinguished the possible etiologies:

> The fact that there was very little coal dust in the sections of the lung tissue and there were no lesions of simple coal workers' pneumoconiosis present, therefore, the exposure to coal dust could not have been the cause of the centrilobular emphysema. If the patient ... smoked cigarettes for over 40 years and he was still smoking up to a few years before he died[.]"

EX 10 at 13-14.

Dr. Caffrey acknowledged that coal mine dust exposure can cause emphysema, but stressed that it results in either focal or centrilobular emphysema. Smoking is the number one cause of the latter type. He explained that coal mine dust causes "[f]ocal emphysema ... a form of centrilobular emphysema[.]" When asked to summarize his rationale about the lack of involvement of coal mine dust exposure, Dr. Caffrey concluded:

> First of all, it was only a very mild amount of anthracotic pigment in the sections of the lung tissue. It was so mild that and the autopsy report from the University of Kentucky Medical center and the VA Hospital they did not diagnose grossly or microscopically changes of coal workers' pneumoconiosis and that is the same thing on the autopsy slides that I saw – a very mild amount of anthracotic pigment and no lesions of simple coal workers' pneumoconiosis. I saw centrilobular emphysema definitely and Mr. Belcher had a 40 plus year smoking history, i.e. the centrilobular emphysema was due to his years of smoking cigarettes in my opinion. Let me say the centrilobular emphysema did not cause Mr. Belcher's death.

EX 10 at 15-16. The "severe vascular that he suffered from "had no cause or effect relationship to his employment in the coal mining industry." EX 10 at 17. Nor was the Miner's impairment related to coal mine dust exposure, Dr. Caffrey reiterated. Id.

Dr. Caffrey is board certified in pathology, and is a Fellow of the American Boards of Anatomical and Clinical Pathology. EX 4. He served as an Assistant Clinical Professor of Pathology at the University of Kentucky School of Medicine from 1965 until 1994. EX 4.

Dr. Lawrence Repsher.

The Miner's medical records were reviewed by Dr. Lawrence Repsher at the request of the Employer. EX 7, EX 13 (corrected). He concluded that coal workers' pneumoconiosis "did not cause, contribute to, or hasten the demise of Mr. Belcher." Dr. Repsher explained that the Miner had "no chest x-ray evidence of coal workers pneumoconiosis." He also concluded that the Miner had no evidence of pneumoconiosis based on pulmonary function testing, arterial blood gas studies or histological evidence. He attributed the Miner's "moderate obstructive ventilatory impairment" to Mr. Belcher's cigarette smoking and not to coal dust exposure. He explained that the "total lung capacity was normal with an increased residual volume, consistent with air trapping and obstructive airways disease. No restrictive impairment was demonstrated." EX 13. The "mild to moderate obstructive ventilatory impairment is the result of chronic bronchitis and centrilobular emphysema, due to a prolonged history of cigarette smoking."

Dr. Repsher also thought that Mr. Belcher had the respiratory capability to resume underground coal mine work prior to his death. He also opined that "[s]ince there was no radiographic or histological evidence of coal workers pneumoconiosis in Mr. Belcher, coal dust exposure did not cause, aggravate, or contribute to the obstructive ventilatory impairment." He also concluded that the chronic obstructive pulmonary disease "was not related to or aggravated by the inhalation of coal mine dust." The Miner's death was not "hastened by the inhalation of coal mine dust[,]" and he found no relationship between the inhalation of coal mine dust and the Miner's acute myocardial infarction. EX 7.

Dr. Repsher acknowledged in deposition testimony that an exposure history of the fifteen to twenty years could result in "either medical or legal pneumoconiosis." EX 9 at 30. He noted that smoking could result in cancer and "catastrophic COPD," but stated that the single greatest risk was the development of coronary artery disease. Id. The autopsy showed that Mr. Belcher had a "developed fibrosing alveolitis, or UIP," with no evidence of pneumoconiosis. Id. at 31-32. Dr. Repsher attributed the ventilatory test abnormalities to smoking, and "the arterial

hypoxemia to small airways disease from that and a variable amount of the hypoxemia to his chronic congestive heart failure." Id.

The doctor opined that the Miner was not disabled from a purely respiratory standpoint. Any disability he suffered was derived from the coronary artery disease. With respect to the COPD, Dr. Repsher stated that the "degree of the COPD is so small that it cannot be measured on the average in a particular individual." Id. at 34. With respect to cause of death, the doctor opined:

> He died of a heart attack, a new acute heart attack, and since there was no evidence that he had any significant coal mine related respiratory disease, his exposure to coal mine dust would not have caused, contributed to or even hastened death.

EX 9 at 35. He explained his conclusion based on the ventilatory tests that showed no significant respiratory impairment, the lack of autopsy or histological findings of pneumoconiosis, and the fact that the Miner did not have any "individually measurable, impairment of his lung function as a result of legal coal workers' pneumoconiosis." Id. at 36. He also cited peer review articles that support his opinions. EX 9 Deposition Exhibit 3.

Dr. Repsher is board certified in internal medicine, with a subspecialty in pulmonary disease, and is a B-reader. He has served as an Associate Clinical Professor of Medicine, Division of Pulmonary Services, at the University of Colorado. EX 8.

Dr. David Rosenberg.

The Employer secured the opinion of Dr. David Rosenberg, who reported on his review of the Miner's file on June 21, 2004. EX 14. Dr. Rosenberg conducted an extensive record survey, and summarized his observations as follows:

> In SUMMARY, at the time of Mr. Belcher's death, he was 70 years of age. He had a long smoking history , as well as over 30 years of coal mine employment. He had a long history of vascular disease, having abdominal aortic aneurysm surgery, as well as having had a stroke with coronary artery disease and pacemaker insertion. He described shortness of breath, and over the years his X-rays did not reveal micronodularity. This was confirmed by CAT scan evaluations. He was noted to have some dependent interstitial changes and a question of congestive heart failure. Extensive pneumonia was noted after his abdominal aortic aneurysm resection. His pulmonary function tests were performed with variable efforts, but at worst demonstrated mild obstruction, and generally, his blood gases were normal for age. Also, his diffusion capacity was reduced. The events surrounding his terminal demise involved a myocardial infarction, and his autopsy demonstrated extensive coronary artery disease, including involvement of the left main coronary artery. Pathology of the lungs revealed extensive emphysema with varying changes of UIP with scattered areas of anthracotic pigment. He did not have findings of micronodularity or coal macules.

Dr. Rosenberg stated that the lung volume measurements did not demonstrate any restriction. The x-rays and CT scan "did not reveal micronodularity related to past coal dust exposure." He concluded that the Miner "did not have the interstitial form of coal workers' pneumoconiosis (CWP). While he appeared to have interstitial changes on chest X-ray which were confirmed on autopsy, this was the picture of an usual interstitial pneumonitis." The doctor said that Mr. Belcher was disabled from a pulmonary standpoint, but opined that any impairment was not caused or hastened by coal dust inhalation or exposure. "He obviously had non-coal mine dust related lung disease in the form of UIP, with varying components of heart failure and

obstructive lung disease with extensive bullous emphysema noted on CAT scan and confirmed at autopsy."

Dr. Rosenberg acknowledged that coal mine dust exposure can cause an airflow obstruction. He explained, however, that "[w]hen this occurs, the coal macule ... develops in the terminal bronchial and is associated with the development of focal emphysema[.]" He further noted, however, that COPD would progress as the "associated macule evolves into micronodular, macronodular disease and potentially complicated pneumoconiosis[.]"

Dr. Rosenberg explained the findings with regards to the causes of the Miner's death:

> With respect to his death, Mr. Belcher's death was directly related to a coronary event in the form of a myocardial infarction secondary to his extensive underlying heart disease. ... [A]t the time of autopsy, he was found to have significant left main coronary artery disease[.] ... The events leading up to the myocardial infarction were associated with increasing respiratory difficulties which related to his usual interstitial pneumonitis and underlying heart problems. These events would have occurred independently of whether he had ever worked in the coal mines. Any potential aggravation of his underlying heart disease by increasing hypoxia, was not related to a coal mine-induced lung disease. As noted above, it was related to UIP and smoking-related COPD.

Dr. Rosenberg concluded that the Miner did not suffer from pneumoconiosis or associated impairment, and that his death was "related to a cardiac event, which was not caused or hastened by underlying CWP."EX 14. Dr. Rosenberg is board certified in internal, pulmonary and occupational medicine. He has been an Assistant Professor of Medicine at the Case Western Reserve University School of Medicine. EX 15.

Dr. Velez.

Dr. Velez authored a "To Whom it May Concern" handwritten letter on April 27, 2000. DX 82. Dr. Velez had been treating the Miner, and found progressive shortness of breath. He also cited to the Miner's 30 years of coal mine employment.

Affidavit of Deceased Miner's Condition.

Mrs. Belcher prepared an Affidavit summarizing the Miner's condition. DX 102. She detailed the fact that Mr. Belcher was required to use oxygen at all times, and that he suffered from very limited breathing.

Dr. Hamilton.

Dr. Hamilton submitted an order for oxygen therapy, and justified this "certificate of medical necessity" with diagnoses of chronic obstructive pulmonary disease and "black lung." DX 75.

Discussion

Introduction

These consolidated claims would normally essentially require different analyses for their resolution. The Miner's claim constitutes a duplicate claim. After the expiration of one year from the denial of the previous claim, a duplicate claim must be denied on the basis of the prior denial unless a Claimant demonstrates with the submission of additional evidence a material change in conditions since the date upon which the order denying the prior claim became final. 20 C.F.R. § 725.309(d).

To assess whether this change is established, the administrative law judge must consider all of the new evidence, favorable and unfavorable, and determine whether the miner has proven at least one of the elements of entitlement previously adjudicated against him. ***Sharondale Corp.***

v. Ross, 42 F.3d 993, 997-98, 19 B.L.R. 2-10 (6th Cir. 1994). The Board has ruled that the focus of the material change standard is on specific findings made against the miner in the prior claim; an element of entitlement which the prior administrative law judge did not explicitly address in the denial of the prior claim does not constitute an element of entitlement "previously adjudicated against a Claimant." See ***Allen v. Mead Corp***., 22 B.L.R. 1-63 (2000) (en banc). If a claimant establishes the existence of that element, he has demonstrated, as a matter of law, a material changes in conditions in the duplicate claim, and would then be entitled to a full adjudication of his claim based on the record as a whole. See ***Tennessee Consolidated Coal Co. v. Kirk***, 264 F.3d 602, 608, 22 B.L.R. 2-288 (6th Cir. 2001); ***Cline v. Westmoreland Coal Co***., 21 B.L.R. 1-69 (1997). In order to meet the threshold requirement for a duplicate or subsequent claim, the newly submitted evidence must also differ qualitatively from the previously submitted evidence. See ***Grundy Mining Co. v. Director, OWCP [Flynn]***, 353 F.3d 467, 477-78, 23 B.L.R. 2-44 (6th Cir. 2003); ***Chaffin v. Peter Cave Coal Co***., 22 B.L.R. 1-294 (2003).

One element of entitlement that was denied in the prior claim is the element of pneumoconiosis, however. That element, of course, must also be established in order to obtain benefits in the survivor's claim. ***Trumbo v. Reading Anthracite Co***., 17 B.L.R. 1-85 (1993). Further, in order to ascertain whether the Claimant has established the existence of pneumoconiosis in her survivor's claim, I must review the administrative record as a whole, regardless of whether the Claimant was able to prove a material change in conditions for the Miner's claim. A denial of the survivor's claim on this basis would thus effectively preclude entitlement on the Miner's claim on the merits.

For the reasons that follow, I find that the Claimant has not established the existence of pneumoconiosis by a preponderance of the record evidence. Because this precludes benefits on the survivor's claim, I conclude that that claim must be denied. ***Trumbo v. Reading Anthracite Co.***, 17 B.L.R. 1-85 (1993). This finding also precludes entitlement on the living Miner's claim, and obviates the need for a duplicate claim analysis, because the survivor's claim requires a necessary review of the entire administrative record at Section 718.202(a).

Timeliness

As stated above, this claim arises within the territorial jurisdiction of the Sixth Circuit. In ***Tennessee Consolidated Coal Co. v. Kirk***, 264 F.3d 602, 22 B.L.R. 2-288 (6th Cir. 2001), that court held:

> The three-year limitations clock begins to tick the first time that a miner is told by a physician that he is totally disabled by pneumoconiosis. This clock is not stopped by the resolution of the miner's claim or claims, and, pursuant to [Ross], the clock may only be turned back if the miner returns to the mines after a denial of benefits. There is thus a distinction between premature claims that are supported by a medical determination ... and those claims that come with or acquire such support. Medically supported claims, even if ultimately deemed "premature" because the weight of the evidence does not support the elements of the miner's claim, are effective to begin the statutory period. Three years after such a determination, a miner who has not subsequently worked in the mines will be unable to file any further claims against his employer, although, of course he may continue to pursue pending claims.

Kirk, 244 F.3d at 608. The Board in ***Furgerson v. Jericol Mining, Inc.***, 22 B.L.R. 1-216 (2002) (en banc) concluded that this language constitutes a holding, and not mere dicta, with respect to duplicate and subsequent claims arising within the territorial jurisdiction of that circuit.

Section 728.308 of the Secretary's regulations in part sets forth a rebuttable presumption that every claim for benefits is timely. 20 C.F.R. § 725.308. I find that this presumption has not been rebutted by evidence of record, because I find that there is no clear indication from this record that the Claimant or Mr. Belcher received an adequate notice of a medical determination of total disability due to pneumoconiosis. At the formal hearing, Mrs. Belcher testified to the effect that she thought that she and her husband had been informed by a physician, apparently Dr. Sundaram, that Mr. Belcher was totally disabled by black lung. This testimony, in the view of the undersigned, does not rebut the presumption of timeliness.

Pneumoconiosis

Under the Act, to receive benefits, a claimant must prove several facts by a preponderance of the evidence. First, a claimant must establish the presence of pneumoconiosis.[13] This is a prerequisite for establishing entitlement in the survivor's claim. Trumbo v. Reading Anthracite Co., 17 B.L.R. 1-85 (1993). Indeed, the threshold issue in the survivor's claim is whether the Miner suffered from coal workers' pneumoconiosis.

Pneumoconiosis under the Act is defined as both clinical pneumoconiosis and/or any respiratory or pulmonary condition significantly related to or significantly aggravated by coal dust exposure:

> For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment. For purposes of this definition, a disease "arising out of coal mine employment" includes any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

20 C.F.R. § 718.201.

Note that the definition appears to combine the first two elements of entitlement, pneumoconiosis and cause of pneumoconiosis. However, the miner bears the burden of establishing both that he or she has pneumoconiosis and that the pneumoconiosis arose out of coal mine employment.

There are four methods for determining the existence of pneumoconiosis:

(1) Under 20 C.F.R. § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence.

(2) Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based, in the case of a living miner, upon biopsy evidence.

(3) Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found to be applicable. In this case, the presumption of § 718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis; § 718.305 is not applicable to claims filed after January 1, 1982. Finally, the presumption of § 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982.

[13] 20 C.F.R. § 718.201.

(4) The fourth and final way in which it is possible to establish the existence of pneumoconiosis under § 718.202 is set forth in subsection (a)(4) which provides in pertinent part:

A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion. 20 C.F.R. § 718.202(a)(4).

Because these claims arise within the territorial jurisdiction of the Sixth Circuit, the Claimant may establish the existence of pneumoconiosis under any one of the alternate methods set forth at 20 C.F.R. § 718.202(a). See ***Furgerson v. Jericol Mining, Inc.,*** 22 B.L.R. 1-216 (2002) (en banc).

20 C.F.R. § 718.202(a)(1)

Upon consideration of the x-ray evidence in this record, I find that the Claimant has failed to establish by a preponderance of the x-ray evidence that the Miner suffered from pneumoconiosis. Of the three chest x-rays that were submitted for the Miner's first claim, none were interpreted as positive. See DX 48. The overwhelming majority of x-rays submitted with the Miner's second claim and for the instant survivor's claim have also been interpreted as negative.[14]

The record includes the following recent x-ray evidence:

X-RAY DATE	***READING DATE***	***EXH.***	***PHYSICIAN/ CREDENTIALS QUALIFICATIONS***	***INTERPRETATION***
02-09-94	02-09-94	DX 8	Lytle	0/0
02-09-94	02-19-98	DX 59	Fino, B	0/0
02-09-94	09-29-98	DX 54	Wheeler, B/BCR15	negative, quality 2
02-09-94	09-28-98	DX 54	Scott, B/BCR16	negative, quality 2

[14] There are numerous x-rays whose interpretations are not classified for the existence of pneumoconiosis. These films were taken during treatment and various hospitalizations at the University of Kentucky. DXs 8, 31, 35, 103. In January and February, 1994, the Miner's films showed a density in the lower left lobe variously interpreted as showing worsening pneumonia and atelectasis. Dr. Lytle on February 9 saw a "slight improvement in interstitial opacities." Mr. Belcher suffered a stroke in March, 1996, and a chest film taken during a resulting hospitalization showed "faint residual bilateral opacities." DX 8. A film taken on the 13th showed no significant change. DX 8. Bibasilar infiltrates also showed up on an x-ray read during a hospitalization on May 17, 1996, for pneumonia. "Infiltrates" and/or "opacities" are noted in later films. DXs 31, 35. Dr. Buck, for example, noted "chronic areas of infiltrates" after reading a November 12, 1996 x-ray. DX 35. A chest x-ray was reported by Dr. Tzouanakis on December 13, 1996 as showing coal workers' pneumoconiosis. DX 31.

[15] Dr. Wheeler has also held various academic positions in the Department of Radiology at the Johns Hopkins School of Medicine. Most recently, Dr. Wheeler has been an Associate Professor of Radiology since 1974, and prior to that an assistant professor of radiology since 1969.

[16] Dr. Scott has also held various academic positions in the Department of Radiology at the Johns Hopkins School of Medicine. Most recently, Dr. Scott has been an Associate Professor of Radiology since 1984, and prior to that an assistant professor of radiology between 1978 and 1984.

03-11-96	03-11-96	DX 8	King	0/0
08-21-96	08-21-96	DX 12	Westerfield, B	no pneumoconiosis, quality 1
08-21-96	09-09-96	DX 11	Sargent, B/BCR	0/1, quality 1
08-21-96	06-03-04	EX 5	Wiot, B/BCR17	no pneumoconiosis; "basilar interstitial disease with associated pleural disease ... not a manifestation of coal dust exposure." Upper lung fields clear. "irregular changes as opposed to the rounded opacities as seen with coal workers' pneumoconiosis." Quality 2.
08-21-96	09-11-98	DX 52	Wheeler, B/BCR	no pneumoconiosis, quality 2
08-21-96	09-08-98	DX 52	Scott, B.BCR	no pneumoconiosis, quality 2
09-23-96	09-23-96	DX 31	Tzouanakis/Clark	pneumoconiosis
10-03-96	10-03-96	DX 14	Broudy	0/1, quality 1
10-03-96	09-11-98	DX 52	Wheeler, B.BCR	no pneumoconiosis, quality 2
10-03-96	09-08-98	DX 52	Scott, B.BCR	no pneumoconiosis, quality 2
10-18-96	10-18-96	DX 35	Univ. Kentucky	emphysema
11-12-96	09-28-98	DX 54	Scott, B/BCR	no pneumoconiosis, emphysema
11-12-96	09-29-98	DX 54	Wheeler, B/BCR	no pneumoconiosis, quality 2
12-13-96	12-13-96	DX 31	Univ. Kentucky	CWP
02-13-97	02-13-97	DX 8	Univ. Kentucky	0/0
02-18-97	02-18-97	DX 35	Univ. Kentucky	CWP
09-30-98	09-30-98	DX 57	R. Sundaram, A	2/3, p/s
09-30-98	02-22-99	DX 65	Scott, B/BCR	no pneumoconiosis, quality 2
09-30-98	02-23-99	DX 65	Wheeler, B/BCR	no pneumoconiosis, quality 2, interstitial fibrosis lower lungs
10-09-98	06-21-04	EX 11	Poulos	Quality 4 – unreadable
10-10-98	06-21-04	EX 17	Poulos	Quality 4 – unreadable
03-11-99	06-21-04	EX 16	Poulos	Quality 4 – unreadable
?	04-09-03	DX 125	Patel, B/BCR	2/1

I find that the preponderance of the x-ray evidence does not establish the existence of pneumoconiosis. Certainly, an administrative law judge is not required to defer to the numerical superiority of x-ray evidence. ***Wilt v. Wolverine Mining Co***., 14 B.L.R. 1-70 (1990). See also Tokarcik v. Consolidation Coal Co., 6 B.L.R. 1-666 (1984). Indeed, a blind deference to numerical superiority of readings must be avoided. Moreover, the adjudicator should not blindly defer to later x-rays, especially where an earlier film is positive. See ***Adkins v. Director, OWCP,*** 958 F.2d 49, 16 B.L.R. 2-61 (4th Cir. 1992). On balance, however, especially given the overall superiority of the credentials of the Employer's experts, I find that, given the preponderance of

[17] Dr. Wiot has been Professor Emeritus of Radiology, University of Cincinnati, since 1998. Before that time, he has served at the University of Cincinnati as a Professor of Radiology from 1966 until 1998, Associate Professor of Radiology from 1962 until 1966, and Assistant Professor of Radiology from 1962 until 1966. He served as President of the American Board of Radiology from 1980 until 1982, and was Chairman of the Task Force on Pneumoconiosis, American College of Radiology, from 1991 until 1997. EX 6.

negative x-ray evidence, the x-rays in the record as a whole do not establish pneumoconiosis. See generally ***Napier v. Director, OWCP***, 89 F.2d 669, 671, 13 B.L.R. 2-117 (4th Cir. 1989); ***Edmiston v. F&R Coal Co***. 14 B.L.R. 1-65 (1990). In the final analysis, given her burden of persuasion, and having conducted a "qualitative," as well as a quantitative evaluation of the x-ray readings, see ***Woodward v. Director, OWCP***, 991 F.2d 314, 321, 17 B.L.R. 2-77 (6th Cir. 1993), I find that the Claimant has failed to demonstrate on the basis of x-ray evidence of record that Mr. Belcher suffered from pneumoconiosis at Section 718.202(a)(1).

20 C.F.R. § 718.202(a)(2)

The second method of determining the existence of pneumoconiosis, as noted above, is by autopsy or biopsy evidence. We have the benefit of both diagnostic methods available for review.

In the autopsy report, Dr. Musgrave noted that Coal nodules and large areas of fibrosis, characteristic of coal workers pneumoconiosis were not present." Although centrilobular emphysema was detected, as well as fibrosis, there were no conclusions of pneumoconiosis. The pigmentation found was attributed to a "pattern commonly seen in urban dwellers and tobacco smokers." DX 120. Although Dr. Racadag, in a consultation review of the autopsy protocol and report, diagnosed, inter alia, pulmonary anthracosis, I defer to the more comprehensive review of the protocol, slides and medical records by Dr. Caffrey, who opined that there was no evidence of coal workers' pneumoconiosis. Dr. Caffrey pointed out that the prosector did not diagnose pneumoconiosis, and emphasized that only a mild amount of anthracotic pigment was discovered. His conclusions are presented in a more comprehensive way, and are buttressed by his review of additional medical records that place in context the autopsy findings. Although both pathologists are board certified, I defer to the Employer's expert with respect to his more extensive and persuasive analysis of the autopsy report. See S***terling Smokeless Coal Co. v. Akers***, 131 F.3d 438, 441, 21 B.L.R. 2-269 (4th Cir. 1997). See generally, ***Clark v. Karst-Robbins Corp***., 12 B.L.R. 1-149 (1989) (en banc); ***Lucostic v. United States Steel Corp***., 8 B.L.R. 1-46 (1985).

Although Dr. Boswell reported "granulomatous inflammation. Increased anthracotic pigment" based on slides prepared after a left lower lobe biopsy, I do not find this to constitute a persuasive diagnosis of pneumoconiosis. Dr. Kleinerman conducted an extensive review of the Miner's medical records on January 11, 1999, and addressed the conclusions of this biopsy report. DX 61. He opined that he slides prepared for the biopsy showed no macules or nodules of coal workers' pneumoconiosis, although there was a "plentiful" amount of black granular pigment.[18]

I find that the Claimant has failed to establish on the basis of autopsy or biopsy evidence that Mr. Belcher suffered from pneumoconiosis. Although anthracotic pigment may certainly constitute pneumoconiosis, and there certainly was a "plentiful" amount of pigmentation detected in the 1999 biopsy slides, on balance there is no persuasive evidence that this was coal workers' pneumoconiosis. The presence of "anthracotic pigment" does not dictate that pneumoconiosis is present. See ***Peskie v. United States Steel Corp***., 8 B.L.R. 1-126 (1985). See generally, ***Griffith v. Director, OWCP***, 49 F.3d 184, 186, 19 B.L.R. 2-111 (6th Cir. 1995). I also accord considerable weight to the autopsy findings and the associated opinions by Employer's experts who reviewed the slides. See ***Peabody Coal Co. v. Shonk***, 906 F.2d 264, 269 (7th Cir. 1990). Although the opinion of the prosector is not automatically entitled to

[18] I have accounted for this finding of "black granular pigment" in assessing the probative value of Dr. Boswell's biopsy conclusions.

deference, see ***Peabody Coal Co. v. McCandless***, 255 F.3d 465, 469, 22 B.L.R. 2-311 (7th Cir. 2001), the fact that pneumoconiosis was not established by the autopsy is one factor that undermines the case for benefits on these claims.

20 C.F.R. § 718.202(a)(3)

The presumptions set forth in this section do not apply to these claims.

20 C.F.R. § 718.202(a)(4)

The Claimant can also demonstrate the existence of pneumoconiosis on the basis of medical opinion evidence. 20 C.F.R. § 718.202(a)(4). A determination of the existence of pneumoconiosis may be made, notwithstanding a negative x-ray, if a physician, exercising sound medical judgment finds that the miner suffers from pneumoconiosis as defined in 20 C.F.R. § 718.201. Any such finding shall be based on objective medical evidence, such as arterial blood gas tests, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion. The interpretations of the CT Scans are also evaluated at Section 718.202(a)(4).

The most recent opinions offered in support of these claims have been submitted by Drs. Tzouanakis, Noss and Sundaram. DXs-30, 31, 35, 37, 57. A discharge summary dated February 26, 1999, and prepared by Dr. Thomas H. Waid, included "coal miner's pneumoconiosis." DX 103. Dr. Tzouanakis had examined the Miner on numerous occasions. On November 12, 1996, he diagnosed pneumoconiosis, CAD, status post AAA repair and reported that Mr. Belcher had suffered a stroke. He noted the presence of infiltrates, and added in a clinic note that they could be related to congestive heart failure. In a letter to Dr. Noss, dated February 18, 1997, Dr. Tzouanakis reiterated his view that the Miner suffered from coal miners' pneumoconiosis. After conducting a medical examination on that date, his diagnoses included pneumoconiosis. DX 35. Dr. Noss authored a "To Whom it may Concern" letter, dated June 3, 1997, which stated that Mr. Belcher "does indeed have coal miner's pneumoconiosis." DX 37. Dr. Noss authored a similar letter on March 7, 2000, concluding that the Miner suffered from pulmonary fibrosis, and said that his chronic pulmonary condition could be classified as pneumoconiosis. DX 72. Dr. Burki had also seen Mr. Belcher at the University of Kentucky in 1997, and found no evidence of pneumoconiosis on a chest x-ray, but still characterized the Miner's clings as "dirty." DX 35.

On examination of the chest, Dr. Waid found crackles and "decreased air exchange." DX 103. This latter diagnosis is not replicated in previous discharge summaries, dated October 9 and 20, 1998. After an earlier hospitalization in October, 1998, Dr. Griffith's discharge summary showed diagnoses of pulmonary embolism and right lower hilar pneumonia. DX 103. His examination of the chest noted clear lungs, with no rales rhonchi or wheezes. DX 103. A chest x-ray read by Dr. Bryant revealed a pneumothorax and no change in the chronic interstitial disease. Dr. Bryant also cited to the CT scan dated June 30, 1998.19 DX 103.

I have carefully reviewed these reports and associated conclusions. Dr. Sundaram's opinions, as presented in a Kentucky State form report, are not as thoroughly reasoned or explained as the extensive opinion reports prepared by the Employer's experts. Further, Dr. Sundaram relies in part on the September 30, 1998 chest x-ray that was reread as negative by Drs. Scott and Wheeler. I defer to the rereadings by the latter radiologists on the basis of their credentials, especially given their extensive academic experience. While a medical opinion diagnosis of pneumoconiosis may be sufficient notwithstanding a negative x-ray, see ***Taylor v. Director, OWCP***, 9 B.L.R. 1-22 (1996), where x-ray evidence constitutes an apparent major part

[19] When the Miner was hospitalized in early 1996, the principal diagnoses were a stroke in March, 1996, and pneumonia in May. DX 8.

of the physician's documentation, his opinion may be entitled to diminished probative weight if that film has been reread as negative. See ***Director, OWCP v. Rowe***, 710 F.2d 251, 255 n. 6, 5 B.L.R. 2-99 (6th Cir. 1983).

The medical opinions of the Employer's experts show a far more extensive analysis and are more adequately documented based on the record as a whole. In the final analysis, taking into account the "qualifications of the respective physicians, the explanations of their medical opinions, the documentation underlying their medical judgments and the sophistication and bases of their diagnoses," see ***Sterling Smokeless Coal Co. v. Akers***, 131 F.3d at 441; see generally ***Clark v. Karst-Robbins Corp***., 12 B.L.R. 1-149 (1989)(en banc); ***Lucostic v. United States Steel Corp***., 8 B.L.R. 1-46 (1985), I find that the medical opinion evidence in the record as a whole does not establish that the Miner suffered from pneumoconiosis. I have duly noted that Dr. Tzouanakis is board certified in internal and pulmonary medicine, and holds a professorship at the University of Kentucky. I have also accepted his status as a treating physician, along with Dr. Noss. The Secretary's regulations provide with respect to treating physicians that:

> [i]n appropriate cases, the relationship between the miner and his treating physician may constitute substantial evidence in support of the adjudicative officer's decision to give that physician's opinion controlling weight, provided that the weight given to the opinion of a miner's treating physician shall also be based on the credibility of the physician's opinion in light of its reasoning and documentation, other relevant evidence and the record as a whole.

20 C.F.R. § 718.104(d)(5). See also 20 C.F.R. § 718.104(d)(1) - (4). Nevertheless, a physician's analysis must be based on adequate documentation. See generally ***Lango v. Director, OWCP***, 104 F.3d 573, 576, 21 B.L.R. 2-12 (3d Cir. 1997). In the final analysis, the credibility of the treating physician's opinion may primarily rest on its "power to persuade." ***Eastover Mining Co. v. Williams***, 338 F.3d 501, 513, 22 B.L.R. 2-625 (6th Cir. 2003). If a treating physician's opinion is not credible, an administrative law judge need not accord additional weight to the treating physician's opinion. See 20 C.F.R. § 718.104(d)(5). See also ***Jericol Mining, Inc. v. Napier***, 311 F.3d 703 (6th Cir. 2002); ***Wolfe Creek Collieries v. Director, OWCP [Stephens],*** 298 F.3d 511, 22 B.L.R. 2-495 (6th Cir. 2002); ***Peabody Coal Co. v. Groves***, 277 F.3d 834, 22 B.L.R. 2-320 (6th Cir. 2002). I note in this regard that Dr. Broudy, for example, had seen the Miner on more than a single occasion, and produced well-documented and reasoned reports of his evaluations. In addition, he has reviewed the medical records to arrive at the conclusion that Mr. Belcher did not suffer from coal workers' pneumoconiosis. His opinions, even taken alone, have considerable probative force. See ***Balsavage v. Director, OWCP***, 295 F.3d 390, 396, 22 B.L.R. 2-386 (3d Cir. 2002) (probative value of report enhanced by opportunity to review extensive medical file).

The CT Scan evidence is evaluated as other evidence. Section 718.202(a)(4). Cf. ***Melnick v. Consolidation Coal Co***., 16 B.L.R. 1-31 (1991)(en banc) (evaluation of CT scan at Section 718.304(c)). The CT scan taken on September 24, 1996 revealed, inter alia , bullous emphysema, an upper lobe nodule, bibasilar atelectasis and infiltrates. DX 13, 31. Dr. Westerfield saw evidence of emphysema and scarring, but no pneumoconiosis. A subsequent CT scan was read by Dr. Kenney as showing, inter alia, granulomatous disease, the upper left lobe nodule. DX 35. Drs. Wheeler and Scott reread the CT scans of September 25 and October 18, 1996 as showing no evidence of pneumoconiosis or silicosis. DXs 52, 54. Dr. Rosenberg opined that the CT scans did not reveal the "micronodularity" associated with pneumoconiosis. EX 14. A hospital radiology note dated October 9, 1998 and authored by Dr. Bryant refers to a

CT scan dated June 30, 1998, which detected "UIP, collagen vascular diseases, or less likely asbestosis." DX 103. Dr. Westerfield concluded that this CT scan did not reveal the small rounded opacities that would suggest the presence of pneumoconiosis. The scarring that was seen in the lower lungs, according to Dr. Westerfield, may be partially related to cigarette smoking "but more likely related to repeated respiratory infection." DX 56 (deposition) at 10-13. Dr. Fino concluded that the CT scan of September 22, 1998 did not show "changes consistent with a coal mine dust related disease." DX 58. The CT scans do not persuasively demonstrate the existence of pneumoconiosis.

I find that the experts utilized by the Employer possess equal or greater expertise in the interpretation of CT scans and chest x-rays. I defer to their rereadings of the CT scans on this basis. See ***Staton v. Norfolk & Western Railway Co***., 65 F.3d 55, 57, 19 B.L.R. 2-271 (6th Cir. 1995).

In addition to the medical evidence submitted in favor of her claims, I have duly considered the affidavit of the Miner's condition and Mrs. Belcher's testimony concerning her husband's severe breathing difficulties in the last months of his live, especially his constant need for oxygen therapy. See generally ***Soubik v. Director, OWCP***, 366 F.3d 226, 231 (3rd Cir. 2004) (extensive and credible lay testimony); ***Mancia v. Director***, OWCP, 130 F.3d 579, 21 B.L.R. 2-114 (3d Cir. 1997).

In making findings with respect to whether the Miner suffered from pneumoconiosis, I have also carefully considered whether there has been persuasive evidence of any chronic pulmonary or respiratory impairment significantly related to, or substantially aggravated by, the Miner's coal mine dust exposure. Certainly, obstructive lung disease, as has been found in these cases, may constitute pneumoconiosis under the Act, see ***Cornett v. Benham Coal Co.***, 227 F.3d 569, 576, 22 B.L.R. 2-107 (6th Cir. 2000) (quoting **Kline v. Director, OWCP**, 877 F.2d 1175, 1178, 12 B.L.R. 2-346 (3d Cir. 1989)), provided it is proven to have been significantly related to or substantially aggravated by Claimant's coal mine dust exposure. See ***Stiltner v. Island Creek Coal Co.***, 86 F.3d 337, 341, 20 B.L.R. 2-246 (4th Cir. 1996); see generally 65 Fed. Reg. 79943 (Dec. 20, 2000) (citing cases). While it is certain that the Miner suffered from emphysema and COPD, there is no credible medical opinion evidence of "legal" pneumoconiosis; no opinion persuasively attributes the Miner's chronic obstructive pulmonary disease to coal mine dust exposure.

To summarize, the evidence of record has not established the existence of pneumoconiosis under any of the distinct methods set forth in Section 718.202(a). The x-ray, biopsy, autopsy and CT scan evidence does not show that it is more likely than not that the Miner had clinical pneumoconiosis. There is no thorough medical opinion in favor of the claim that, notwithstanding a negative x-ray, makes a persuasive diagnosis of "legal" pneumoconiosis. Further, the medical opinion evidence of the Employer's experts, as bolstered by the clinical documentation of record, and strengthened by the fact that, overall, their opinions are more adequately detailed and explained, serve at the least to preclude a finding of pneumoconiosis. Entitlement has not been proven for the survivor's claim. Even assuming that the Claimant established a material change in conditions, especially as based on the presence of a totally disabling pulmonary or respiratory impairment, I would likewise find, based on the record as a whole, that pneumoconiosis would not be established in the Miner's claim.

Conclusion

Because the Claimant has not proven that the Miner suffered from pneumoconiosis, or any pulmonary or respiratory impairment significantly related to, or substantially aggravated by, coal mine employment, she is not entitled to benefits under the Act on either claim. Trumbo.

Attorney's Fees

The award of an attorney's fee under the Act is permitted only in cases in which Claimant is found entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of attorney's fees to the Claimant for representation services rendered in pursuit of the claim.

ORDER

It is hereby ordered that the claims of **INIS BELCHER, o/b/o ELMER BELCHER**, and as surviving widow of **ELMER BELCHER**, are ***DENIED***.

A

DANIEL F. SOLOMON
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision and Order by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of this notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.